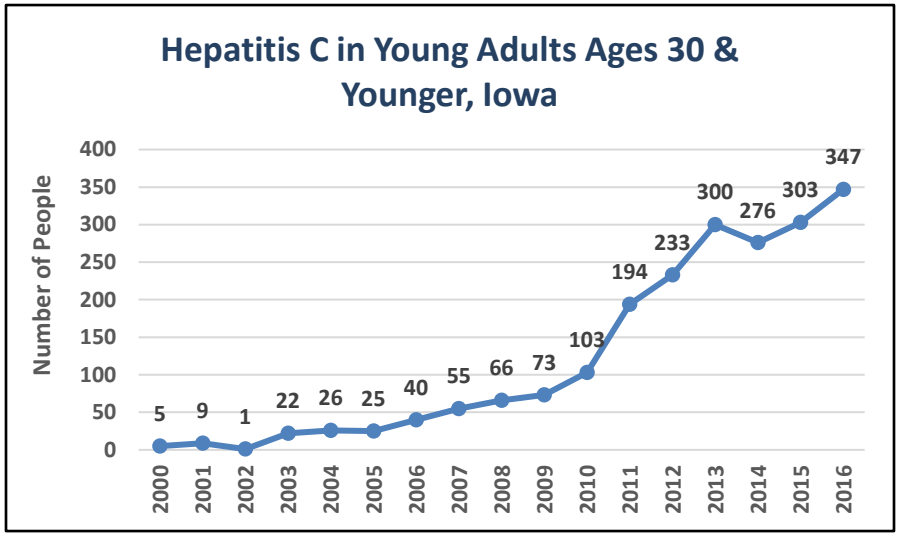
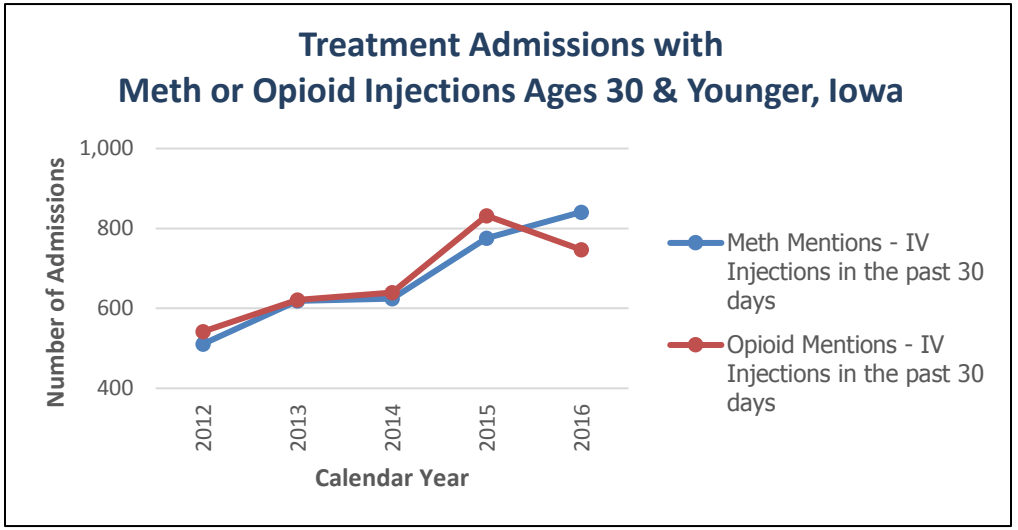
Iowa has a growing Hepatitis C problem and it's partially due to the increasing use of injectable drugs (opioids, meth) by Iowans, especially those under 30.



Diagnoses of Hepatitis C have increased sharply for Iowans ages 30 and younger.



Admissions have increased for substance use treatment due specifically to injection of opioids and injection of methamphetamine for Iowans ages 30 and younger.

Source for both charts: Iowa Department of Public Health

What do we know?

Injection drug use is the main driver for increases in new, hepatitis C cases among young adults. The recent increase in abuse of prescription and non-prescription opioids is contributing to the increase in cases. In Iowa, diagnoses among our young people (30 and under) have significantly increased (237%) since 2010.

Hepatitis C can spread easily through surfaces, equipment, or objects contaminated with infected blood. People who inject drugs can acquire and spread hepatitis C through contaminated needles, syringes, water, cotton, and other equipment. Of the young adults ages 30 and under diagnosed **in 2016, 68% reported using injection drugs** to their medical provider.

What can we do?

Getting people into substance use treatment not only helps with addiction but also with the spread of Hepatitis C. Entering treatment removes the individual from easy access to drugs as well as non-sterile environments that have been found to be conducive to contracting Hepatitis C.

Syringe Services Programs (SSPs) are a proven method of getting people into treatment. One study in particular found that users of SSPs were five times more likely to enter treatment then those who did not participate.[1]

The first legal SSP in the US began in Washington State in 1988[2]. Here are some highlights from several other states that have SSPs with an emphasis on treatment referrals:

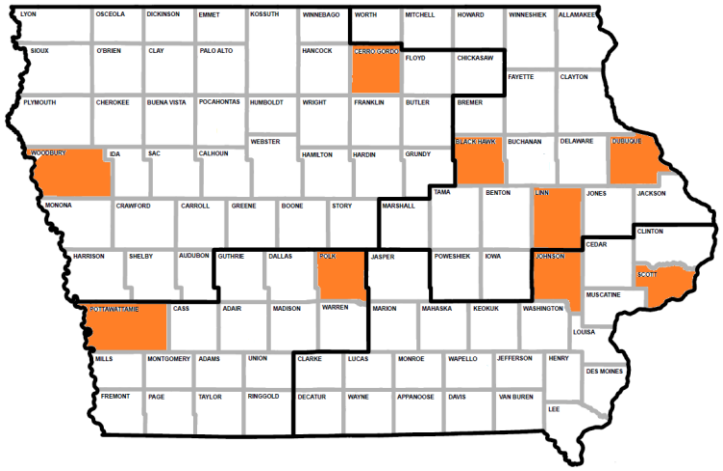
…reduced drug use and increased drug treatment enrollment associated with needle exchange participation may have many public health benefits, including prevention of blood-borne viral transmission.[1]

North Carolina	**Wisconsin**	**New Jersey**
Since 2015, North Carolina has made 3,766 referrals to substance use disorder treatment and distributed 5,682 naloxone kits. Program participants have reported 2,187 overdose reversals.	In 2015, 8,046 referrals to drug treatment were made in Wisconsin[3]. Over the course of one week, 40% of participants entered treatment when offered services by a case manager or social worker[3].	Between 2006 - 2011, the SSP in New Jersey enrolled 9,912 participants. 22% of those participants (2,160) were admitted to methadone or suboxone treatment programs.
Maryland	**Connecticut**	**Washington State**
A 2006 study of 1,490 people who injected drugs in a Maryland community explored whether or not people sought out treatment services through SSPs. Between 1994 and 1998 when the first SSP opened in the community, 25% of the SSP program participants entered detoxification. The study found that SSP participants were 3.2 times more likely to enter detoxification than people in the community who used drugs but did not participate in the SSP[2].	In the first seven months of operation of the New Haven SSP, 25% of participants requested drug treatment referrals. 60% of those individuals subsequently entered a detoxification program[5].	A 2000 study of SSP participants in Seattle found that people who participated in a SSP were 2.5 times more likely to reduce injection frequency than those who had never participated. SSP participants were also 3.5 times more likely to stop injecting drugs all together. New users of SSPs were five times more likely to enter drug treatment programs than those who did not use SSPs[6]. In 2016, 5,294 people were referred through a SSP to drug treatment.

- Other states with SSPs include: **Hawaii, Florida, New Mexico, New York, Utah and Indiana.**

Who can help?

Eighteen community-based organizations, clinics and local public health agencies currently hold contracts with the Bureau of STDs, HIV, and Hepatitis at the Iowa Department of Public Health.



Ten of these organizations provide HIV and hepatitis C testing, immunizations for hepatitis A and B, STD testing, risk reduction services, condom distribution, and referrals to treatment for infectious diseases. These organizations reach relatively large numbers of people at risk and are required to do outreach to populations at risk for HIV and hepatitis C. Several work closely with the Iowa Harm Reduction Coalition which provides outreach services to people who use drugs.

Eight other agencies provide services only to those living with HIV, but these services include case management services, financial assistance, referrals to substance use and mental health treatment, and housing assistance. These community-based service providers might reach smaller numbers of people who inject drugs, but they likely have better long-term relationships with those clients, and could provide clean syringes and other equipment and supplies to them.

IDPH will use **existing funds** already provided to these organizations to implement SSPs in Iowa by adding SSP as a potential intervention/prevention service. SSP expenses include staff time and supplies. The organizations which receive federal funding from IDPH will be able to use this existing funding for all SSP program expenses except syringes. To purchase syringes, organizations will be encouraged to use local/county funds and/or apply for foundation funds.

Through our insurance premiums or tax dollars, all Iowans are paying for medical costs associated with hepatitis. Prevention of transmission means reduced expenditures.

IDPH supports client membership card model. The membership cards identify an individual as a client of a specific SSP and protect them from prosecution for having drug paraphernalia. In addition to syringes, SSP clients are generally given packets with cottons, sterile water, bleach, and other supplies. Clients should be taught how to use the equipment to minimize risk of infectious disease transmission, and how to destroy and/or return used equipment. Use and distribution of naloxone is also common in SSPs.

Syringe Services Have Been Studied

Due to the longevity of this prevention practice, many studies have been authored to address the concerns of efficacy, public safety, and cost effectiveness of Syringe Services Programs.

HIV and Hepatitis C Prevention Outcomes
World Health Organization (WHO). Evidence for action technical papers: effectiveness of sterile needle and syringe programming in reducing HIV/AIDS among injecting drug users. 2004. www.emro.who.int/aiecf/web301.pdf
Wodak, A., & Cooney, A. (2006). Do Needle Syringe Programs Reduce HIV Infection Among Injecting Drug Users: A Comprehensive Review of the International Evidence. Substance Use & Misuse, 41(6-7), 777-813. https://www.ncbi.nlm.nih.gov/pubmed/16809167
Substance Use Disorder Treatment Outcomes
Hagan H, et al. Reduced injection frequency and increased reentry and retention in drug treatment associated with needle-exchange participation in Seattle drug-injectors. J Substance Abuse Treat. 2000. http://www.ncbi.nlm.nih.gov/pubmed/11027894
Strathdee, Steffanie A., et al. "Needle-exchange attendance and health care utilization promote entry into detoxification." Journal of Urban Health 76.4 (1999): 448-460. https://link.springer.com/article/10.1007/BF02351502
Public Safety Outcomes
Marx, M.A., et al. Trends in crime and the introduction of a needle exchange program. (2000): *American Journal of Public Health* 90, no. 12 pp. 1933-1936. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1446444/
Groseclose, S. L., et al. Impact of Increased Legal Access to Needles and Syringes on Practices of Injecting-Drug Users and Police Officers -- Connecticut, 1992-1993. (1995). Journal of Acquired Immune Deficiency Syndromes & Human Retrovirology, 10(1). https://www.ncbi.nlm.nih.gov/pubmed/7648290
Doherty, M. C., et al. Discarded Needles Do Not Increase Soon After the Opening of a Needle Exchange Program. (1997). American Journal of Epidemiology, 145(8), 730-737. https://www.ncbi.nlm.nih.gov/pubmed/9125999

[1] Reduced injection frequency and increased entry and retention in drug treatment associated with needle-exchange participation in Seattle drug injectors. H. Hagan, J. P. McGough, H. Thiede, S. Hopkins, J. Duchin, E. R. Alexander J Subst Abuse Treat. 2000 Oct; 19(3): 247–252.

[2] The first NEP in the United States opened in Washington State in 1988 (Des Jarlais; Des Jarlais et al., 2006).

[3]Strathdee, Steffanie A., et al. "Needle-exchange attendance and health care utilization promote entry into detoxification." *Journal of Urban Health* 76.4 (1999): 448-460. https://link.springer.com/article/10.1007/BF02351502. Retrieved from http://www.iowaharmreductioncoalition.org/ on February 23, 2018.

[4]Danelski, Lisa. Personal communication. AIDS Resource Center of Wisconsin. October 5, 2017. Retrieved from http://www.iowaharmreductioncoalition.org/ on February 23, 2018.

[5]Heimer, Robert. "Can syringe exchange serve as a conduit to substance abuse treatment?." *Journal of substance abuse treatment* 15.3 (1998): 183-191. http://www.sciencedirect.com/science/article/pii/S0740547297002201

[6]Hagan, Holly, et al. "Reduced injection frequency and increased entry and retention in drug treatment associated with needle-exchange participation in Seattle drug injectors." *Journal of substance abuse treatment* 19.3 (2000): 247-252. http://www.sciencedirect.com/science/article/pii/S0740547200001045

For more information, please contact:
Deborah Thompson, Policy Advisor/Legislative Liaison for IDPH
Deborah.Thompson@idph.iowa.gov / 515-240-0530
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